SOUTH CAROLINA DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS

☐ MR ☐ RD ☐ Autism ☐ TBI ☐ SCI ☐ SD ☐ Other

REQUEST FORM—INDIVIDUAL AND FAMILY SUPPORT STIPEND/RESPITE

Consumer: _____

Local Provider: _____

DSN/Home Board: _____

Referring Provider Staff: _____ **Telephone:** _____

Local Provider Action

Received Date: _____ **Review Date:** _____

☐ **Approved** **Amount: $**_____ **Approved Period:** _____

☐ **Denied (See reason below)** ☐ **No Action, Return to Referring Staff (See below)**

Comments: _____

_____

_____

_____

_____

_____

_____ _____

Local Provider Administrator **Date**

DSN/Home Board If Different From Above

Received Date: _____ **Review Date:** _____

☐ **Approved** **Amount: $**_____ **Approved Period:** _____

☐ **Denied (See reason below)** ☐ **No Action, Returned to Referring Staff (See below)**

Comments: _____

_____

_____

_____

_____

_____ _____

DSN/Home Board Provider Administrator **Date**

Consumer Information

Name: _____ **Age/Birth Date:** _____

Address: _____ **Phone: (____)** _____

_____ **Medicaid #:** _____

SS#: _____

Number residing in household _____

Check All That Apply:

☐ **Medicaid Eligible** ☐ **Waiver Enrollment Pending**

☐ **Medicaid Eligibility Pending** ☐ **Waiver Waiting List - Critical**

☐ **Community Choices Waiver** ☐ **Waiver Waiting List – Non-Critical**

Is the consumer currently employed? ☐ **Full-time** ☐ **Part-time** ☐ **No**

Monthly Household Income

(If additional space is necessary, attach worksheet to this form)

Income Sources	**Amount**

Total Monthly Income **$**_____

(Attach copy of Income verification) **Income Verification Valid Six Months**

I certify that the above consumer information is true and complete. I understand that submitting false information or use of Individual and Family Support Funds or respite for purposes other than as requested may result in termination of assistance and a payback of expended funds to DDSN.

_____ _____

Consumer or Parent or Legal Guardian **Date**

Request Information

Type Request	Amount Needed	Amount Requested	Approval Period
☐ One-Time	$_____	$_____	_____
☐ Ongoing *	$_____	$_____	_____

***(Provide detailed information about costs of items requested.)**

Justification

Explain the purpose/objective, how it will be used and for what service/need and how it ties back to the two priorities listed in Directive 734-01-DD.

_____

_____

_____

_____

_____

Assurance of Resource Review

Other resources utilized/contributed to assist with requested need:

☐ **Consumer/Family** **Amount $**_____

☐ **Private Insurance/Medicare/Medicaid** **Amount $**_____

☐ **Private, Non-Profit (Specify)** _____ **Amount $**_____

☐ **Public Agency (Specify)** _____ **Amount $**_____

☐ **Social Security PASS (Plan for Achieving Self Support)** **Amount $**_____

☐ **IRWE (Impairment Related Work Expense)** **Amount $**_____

☐ **Other (Specify)** _____ **Amount $**_____

_____ _____

Referring Provider Staff **Date**

_____ _____

Reviewing Supervisor **Date**